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References

- 1 Marino B, De Simone G, Pasquini L, Piva R, Schicchi F, Ballerini L. Ecocardiografia 2D del tratto di efflusso ventricolare destro. *Revista Latina de Cardiologia* 1983; 4: 71-2.
- 2 Marino B, Ballerini L, Piva R, *et al.* Proiezione obliqua anteriore destra nella tetralogia de Fallot: correlazioni anatomo-eco-angiocardigrafiche. *Revista Latina de Cardiologia* (in press).

This letter was shown to Dr Silove and colleagues, who reply as follows:

Sir,

We are pleased that Marino *et al* have confirmed that the echocardiographic plane we described is the method of choice for evaluating right ventricular outflow obstruction. Their use of the term "right oblique" is not quite appropriate in echocardiography; in our spoken presentation at the Meeting of the Association of European Pediatric Cardiologists 1981¹ we indicated that the plane was roughly equivalent to the angiographic right oblique projection, and presumably this is what they mean. Silverman *et al* use

the term "parasagittal short axis" to describe a similar echocardiographic plane.² The plane we described is neither parasagittal nor paracoronal, since it lies approximately midway between the two.

Our study was not designed to evaluate various planes for differentiating the sites of ventricular septal defects, and we made the point that "the ventricular septal defect was assessed by several routine views." The paper by Sutherland *et al* deals comprehensively with the detection of ventricular septal defects³ and would support the suggestion that a subcostal parasagittal short axis plane may be helpful in determining the site of the defect.

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References

- 1 Silove ED, Shiu MF. Subcostal two-dimensional echocardiographic evaluation of tetralogy of Fallot [Abstract]. *Pediatr Cardiol* 1982; 3; 78.
- 2 Silverman NH, Hunter S, Anderson RH, Ho SY, Sutherland GR, Davies MJ. Anatomical basis of cross sectional echocardiography. *Br Heart J* 1983; 50; 421-31.
- 3 Sutherland GR, Godman MJ, Smallhorn JF, Guiterras P, Anderson RH, Hunter S. Ventricular septal defects. Two dimensional echocardiographic and morphological correlations. *Br Heart J* 1982; 47; 316-28.

Persistent left ventricular disease in clinically "cured" primary endocardial fibroelastosis

Sir,

Schneeweiss *et al* (1983; 50: 252-6) state that "there is some disagreement concerning the possibility of the clinical diagnosis of primary endocardial fibroelastosis" and base their diagnosis only on indirect and unspecific findings. Such follow up observations seem to me of little evidence, because the direct histological proof is missing. It could, however, be obtained by the simple and safe technique of endomyocardial biopsy, as demonstrated by Neustein *et al*¹ and our group.² During the past two years we could, by this technique, differentiate six patients with endocardial fibroelastosis from six patients with primary dilated cardiomyopathy in a group of 12 children, fulfilling all the criteria of primary dilated endocardial fibroelastosis mentioned by Schneeweiss *et al*.

Thus, without histological proof, paediatric cardiologists too should follow the recommendations of the WHO/ISFC task force³ and call a dilated left ventricle with bad function—having excluded various known causes—a primary dilated cardiomyopathy.⁴

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References

- 1 Neustein HB, Lurie PR, Fugita M. Endocardial fibroelastosis found on transvascular endomyocardial biopsy in children. *Arch Pathol Lab Med* 1979; 103: 214-9.
- 2 Schmaltz AA, Apitz J, Hort W. Endomyocardial biopsy in infants and children: technique, indications and results. *Eur J Pediatr* 1982; 138: 211-5.
- 3 WHO/ISFC task force. Report on the definition and classification of cardiomyopathies. *Br Heart J* 1980; 44: 672-3.
- 4 Schmaltz AA, Apitz J, Quintenz R, Lang D, Kupferschmid Ch, Hort W. Gibt es eine primäre dilatative Kardiomyopathie im Kindesalter? *Paediatrische Praxis* 1982/83; 27: 257-64.

This letter was shown to the authors, Dr Schneeweiss and colleagues, who reply as follows:

Sir,

We completely agree with Dr Schmaltz's remark that histological studies of biopsy specimens would improve the accuracy of giving names to conditions of dilated, poorly contracting left ventricle.

We are confident that Dr Schmaltz would agree with us that the role of endomyocardial biopsy in children, particularly its practical value in paediatric cardiology, is very controversial.^{1,2} Serious complications such as cardiac perforation, tamponade, pneumothorax, arrhythmias, heart block, air embolism, right recurrent laryngeal nerve paresis, and right phrenic nerve paresis, although rare, were reported to result from endomyocardial biopsy.^{3,4}

In Dr Schmaltz's paper,¹ only two of 14 biopsy studies were considered by the authors to be diagnostic. Some of the remainder were helpful but were not considered by Dr Schmaltz as diagnostic. These cannot be considered to be direct or specific findings. Furthermore, 10 of the 14 patients studied by Dr Schmaltz were over the age of 1 year, which is very

frequently beyond the age at which fibroelastosis presents. The only patient in whom Dr Schmaltz found the myocardial biopsy to be diagnostic for endocardial fibroelastosis was a 3 year old child.

Based on our experience, we feel that under the age of 6 months children present a distinct clinical picture, and we therefore feel that biopsy should be limited only to babies in whom the biopsy results may affect treatment.

We certainly support Dr Schmaltz's point that without histological proof cardiologists should follow the WHO/ISFC task force recommendations and, having excluded various known causes, diagnose dilated cardiomyopathy when we see a dilated, poorly contracting left ventricle.⁵

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References

- 1 Schmaltz AA, Apitz J, Hort W. Endomyocardial biopsy in infants and children: technique, indications and results. *Eur J Pediatr* 1982; 138: 211-5.
- 2 Mackay EH, Littler WA, Sleight P. Critical assessment of diagnostic value of endomyocardial biopsy. *Br Heart J* 1978; 40: 69-78.
- 3 Mason JW. Techniques for right and left ventricular endomyocardial biopsy. *Am J Cardiol* 1978; 41: 887-92.
- 4 Grossman W. Therapeutic uses of the catheter and special diagnostic techniques. In: Grossman W, ed. *Cardiac catheterization and angiography*. Philadelphia: Lea & Febiger, 1980: 403-13.
- 5 WHO/ISFC task force. Report on the definition and classification of cardiomyopathies. *Br Heart J* 1980; 44: 672-3.

Correction

We regret the error in the letter to the Editor by Kay *et al* (1984; 51: 237-8). The last sentence in the left hand column of p 238 should have read: "The position of the graft on the subclavian artery may be important since a 5 mm subclavian near to the aorta will carry 25 ml/s but further away at 3 mm diameter will only carry 3-25 ml/s."

Notices

Postgraduate course on cardiology

A course on the clinical application of new procedures in cardiology is to be held at the Postgraduate Medical School, Budapest, Hungary, from 23 to 29 September 1984. For further information, please contact: Profes-

sor Zoltán Antalóczy, 2nd Medical Clinic, Postgraduate Medical School, PO Box 112, H-1389 Budapest, Hungary.

British Cardiac Society

The Autumn Meeting in 1984 will be held on 3 and 4 December 1984, and the closing date for receipt of abstracts will be 15 August 1984.